ALCOHOL AND CONTROLLED SUBSTANCES TESTING CONSENT FORM

TO BE SIGNED BY ALL COMMERCIAL DRIVERS - LICENSED EMPLOYEES COVERED BY THE FEDERAL CDL DRUG AND ALCOHOL TESTING REGULATIONS

As a condition of my continued employment as an operator of controlled commercial motor vehicles, I consent to alcohol and controlled substances testing, as stated in the Department's Alcohol and Drug-Free Workplace Policy and the Alcohol and Controlled Substances Testing Procedures Policy.

I understand that if I test positive for alcohol or controlled substances, I will be subject to disciplinary action up to and including dismissal from employment.

I further agree that, in the event I am involved in an on-the-job commercial motor vehicle accident (as defined by the terms of the Department's alcohol and controlled substances testing procedures), I authorize release of relevant hospital reports or other documentation that would indicate whether there were alcohol and/or controlled substances in my system at the time of the accident.

I understand that the collection, testing and reporting of my specimen or evidential breath test will be done in accordance with standard chain of custody procedures. If I am taking any prescription medication at the time of the test, I will be given the opportunity to reveal that information to the Medical Review Officer, if contacted.

I consent to the release of my test results received from the contracted Laboratory and Medical Review Officer to Department management designated to receive such results. I understand that the test results will be held in **confidence** by Department management and only released to supervisors on a **"need to know"** basis.

I have read and understand the terms of the Department's Alcohol and Drug Free Workplace Policy and Alcohol and Controlled Substances Testing Procedures Policy. I have also received a copy of 49 CFR Part 382, Federal Motor Carrier Safety Regulations.

_____

Employee's Name (Type or Print) SSN Bureau/Region/Park

_____ _____

Employee Signature Date

Return to the Human Resource Office **immediately** after employee has signed.

SAMPLE CONDITIONAL JOB OFFER LETTER

Department Memorandum

DATE:

TO:

FROM:

SUBJECT: PRE-EMPLOYMENT CONTROLLED SUBSTANCES TESTING

You have been offered and have accepted a position with the Idaho Department of Parks and Recreation starting _____. The Department is required to administer an Alcohol and Controlled Substance Program to comply with The Federal Motor Carrier Safety Regulations Title 49 CFR, Part 382. Your job offer is conditional upon the receipt of a negative pre-employment controlled substances test result and verification from previous employers for the last two (2) years, or portion thereof, of no positive alcohol and/or controlled substances tests, refusal to be tested, or failure to report for a required test. If a previous employer reports any of the above, you must submit proof of a professional substance abuse evaluation, participation in follow-up treatment or successful completion of a rehabilitation program, obtaining a negative return-to-duty test, and/or being subject to follow-up testing.

Enclosed is a copy of the Federal Regulations, Part 382, and Driver Briefing and Instructions. After you have read these, please sign the Pre-Employment Urinalysis Consent form and return it to our office in the enclosed envelope.

Your supervisor will make your appointment for testing and contact you with instructions about when and where to appear for the test. There will be no charge to you for the test. The collection site will notify the proper person at the Department with test results.

While completing your hiring papers, authorization to contact your previous employer(s) for the past two years will be requested. Please bring their address(es) and phone number(s) with you. Previous employers are asked if you were in an Alcohol and/or Controlled Substances Test Program while driving a commercial vehicle for them and the results of those tests.

If you have any questions please call me at (208)_____ .

Sincerely,
(SUPERVISOR)

WITHDRAWAL OF CONDITIONAL JOB OFFER

[DATE]

[APPLICANT NAME]
[APPLICANT ADDRESS]
[APPLICANT ADDRESS]

Dear [APPLICANT],

Applicants who are made a conditional offer of employment for a position that requires a Commercial Drivers License (CDL) must obtain a negative pre-employment controlled substances test result, and must have no positive tests documented by previous employers for the last two (2) years, or portion thereof (or provide proof of a professional substance abuse evaluation, participation in follow-up treatment or successful completion of a rehabilitation program, obtaining a negative return-to-duty test, and/or being subject to follow-up testing), in accordance with Federal Regulations.

Based on the following, the Idaho Department of Parks and Recreation now withdraws its conditional offer of employment.

____ You obtained a positive controlled substances test result.

____ A previous employer reported:
___ a positive alcohol and/or controlled substances test
___ a refusal to submit to a test
___ failure to report for a test

____ You cannot provide proof of a professional substance abuse evaluation, participation in follow-up treatment or successful completion of a rehabilitation program, obtaining a negative return-to-duty test, and/or being subject to follow-up testing.

You cannot be considered again for a Department position that requires a CDL for a twelve (12) month period.

After this twelve (12) month period, proof of a substance abuse professional evaluation and participation in follow-up treatment or successful completion of a rehabilitation program must be provided before you can be considered for employment in a position requiring a CDL.

Sincerely,

Human Resource Officer

DRIVER PROGRAM PARTICIPATION
VERIFICATION AND RELEASE

Purpose of Form: The Alcohol and Controlled Substances Testing Rule requires employers of commercial and motor vehicle drivers, including temporary or contract drivers, participating in an alcohol and drug testing program administered by another entity to verify that: (a) the driver participates in the program; and (b) the program meets the Federal Highway Administration requirements. The driver's written authorization is necessary for the release of alcohol and drug testing information. This form addresses both the verification and consent requirements.

EMPLOYEE PLEASE COMPLETE THE FOLLOWING:

I, _____hereby authorize the testing program named herein to release
Employee's Name (Print) _____
pertinent information regarding alcohol and drug tests performed on myself for an employing motor carrier and/or the FHWA.

Employee's Signature _____

Employer: _____ Phone: _____

Location: _____
(Street) *(City)* *(State)* *(Zip)*

Contact: _____
Name (Print) *(Title)*

PREVIOUS EMPLOYER COMPLETES THE FOLLOWING (ALSO FOLLOWING PAGE)

The above-named driver:___ participated___ did not participate in the above-named alcohol and/or drug testing program.

Dates of participation: From: _____ To: _____

Specimen Collection Entity:
Name: _____
Address:_____

Testing Laboratory:
Name: _____
Address: _____

Medical Review Officer:
Name: _____
Address:_____

Has this driver ever refused a drug test: ___Yes ___No
Has this driver ever refused an alcohol test: ___Yes ___No

This driver ____ is ____ is not qualified to drive a commercial motor vehicle.

Verified By: _____ Title: _____

Date:_____/_____ /_____
(Month) *(Day)* *(Year)*

PLEASE RETURN THIS AND THE PRECEDING PAGE IN A CONFIDENTIAL ENVELOPE TO:
IDAHO DEPARTMENT OF PARKS AND RECREATION, HUMAN RESOURCE OFFICE
PO BOX 83720, BOISE ID 83720-0065

Enter test result information in the space provided. Begin with the most recent test.

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___Negative ___Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Type of Test: ______________________
Date of Test: ______/______/_______ Result of Test: ___ Negative ___ Positive
Month Day Year

Comments: ____

PRE-EMPLOYMENT URINALYSIS CONSENT

I understand by the *Federal Motor Carrier Safety Regulations, Title 49 United States Code of Federal Regulations, Part 40, Part 382*, and the *Omnibus Transportation Employee Testing Act of 1991*, that all prospective commercial vehicle drivers must submit to a controlled substances test.

A urine sample will be collected and tested for controlled substances.

I also understand that if I test positive for use of a controlled substance, I am not medically qualified to operate a commercial motor vehicle.

The Medical Review Officer, who will report to the Department whether the test results were negative or positive, and if positive, will maintain the identity of the controlled substance for which the test was positive. The results will not be released to any additional parties without my written authorization.

I hereby agree to submit to a drug screen urinalysis, and consent to the release of my test results from the contracted laboratory and Medical Review Officer to Idaho Department of Parks and Recreation management designated to receive such results.

_____ _____

Applicant Name Social Security Number

_____ _____

Applicant Signature Date

DRIVER BRIEFING AND INSTRUCTIONS FOR DRUG TESTING

You Have Been Selected For Urine Drug Testing

The collection of your urine will be conducted under the procedures required by mandatory Federal regulations, and the Federal Highway Administration. These regulations allow for individual privacy, unless there is reason to believe that a particular individual may alter or substitute the urine specimen to be provided. The collection site personnel will take precautions to ensure that your specimen is not adulterated or diluted during the collection procedure. Your specimen collection must also follow strict "chain of custody" and security procedures.

In Addition:

Photo identification must be presented at the collection site.

? You will remove any unnecessary outer garments, such as coat or jacket.

? All personal belongings, like briefcases, will remain with the outer garments. You may retain your wallet.

? You will be instructed to wash and dry your hands prior to providing a specimen.

? You will be provided a sealed collection container or bottle, or it will be unwrapped in your presence.

? Your specimen will be provided in the privacy of a stall or otherwise partitioned area that allows for individual privacy.

? After handing the specimen bottle to the collector, you should keep the specimen in full view at all times until it is sealed and labeled. This protects you against the wrong label being put on your bottle or someone possibly tampering with your specimen.

? If the collection site person has reason to believe that you may have altered or substituted the specimen, the person will notify a higher level supervisor. Should you tamper, adulterate, or in any way attempt to dilute the specimen, the collection site person may request authorization to collect a second specimen under direct observation by the same gender collection site person.

? If you alter or adulterate your sample during a pre-employment test, you will be considered medically disqualified for the job that requires the CDL. You will not be allowed to reapply for that type of position for the following twelve months.

? You will be asked to initial the identification label on the specimen container for the purpose of certifying that it came from you.

? You will also be asked to provide information on the Chain of Custody Form, Section VII, on copies 3 through 6 only, and certify that the urine specimen identified as having been collected from you is, in fact, the specimen you provided. You will receive copy 4 of the Chain of Custody Form on which you may want to make a list of medications you are taking.

? Applicant: After the laboratory analysis, the results will be forwarded to the designated employer through their testing contractor. An adulterated test or a positive test result will medically disqualify you for a job requiring a CDL. You will not be allowed to reapply for that type position for the following twelve (12) months, and will then be asked to furnish a substance abuse professional's evaluation and complete a controlled substance test with negative results.

DRIVER BRIEFING AND INSTRUCTIONS FOR DRUG TESTING (cont)

? Current Employees: After the laboratory analysis, the results will be forwarded to the Medical Review Officer working for your employer. Prior to making a final decision to verify a positive test result to your employer, the Medical Review Officer will give you an opportunity to discuss the test results and submit medical documentation of legally prescribed medications.

? A complete listing of the collection procedures may be found in Title 49 CFR, Part 40.25.

PLEASE TELL THE COLLECTION SITE PERSONNEL YOU ARE BEING TESTED

FOR THE IDAHO DEPARTMENT OF PARKS AND RECREATION

DRUG/ALCOHOL TEST AUTHORIZATION

To the Employee:
As part of the State of Idaho's Random Drug Testing for CDL Holders Program, you are required to report (with this form) for a Drug and/or Alcohol test to:

Collection Site:
Address:
Date:
Phone:
Time:

?? You must bring **photo I.D.** when reporting for your test.
?? Failure to report will be considered a refusal to take the test.

To the Collection Site:

Employee Name:
SS#:
Phone:
The above ___**DOT** ___**Non-DOT** Employee has been selected for a:

___Pre-Employment ___Random ___Post Accident/Incident

___Reasonable Cause ___Follow Up ___Return to Duty

___DRUG **___ALCOHOL** **___DRUG & ALCOHOL**
Authorized by:
Company:
Phone:

COLLECTION SITE:

1. *Immediately following the test,*
   Fax the MRO copy of the Chain of Custody & this form to 877-673-5665
   Fax the Employer copy of the Alcohol Chain of Custody and this form to 877-673-5665

2. *Within 24 hours of the test.*
   Mail the MRO copy of the Chain of Custody to:
   Premier Medical Services MRO Department
   4747 Glenwood Suite 103
   Boise, ID 83714

3. Mail the Employer copy of the Chain of Custody to:
   Wienhoff & Associates, Inc.
   4747 Glenwood Suite 102
   Boise, ID 83714

4. Please send invoices to Wienhoff & Associates, Inc.

REQUEST FOR ALCOHOL AND/OR CONTROLLED SUBSTANCES TEST RESULTS

As a condition of my qualification as a driver of the Idaho Department of Parks and Recreation commercial motor vehicles, I consent to the alcohol breath testing and controlled substances testing as required by the Federal Motor Carrier Safety Regulations Title 49 CFR, Part 382.

I understand a positive test for alcohol or controlled substances, based on the breath alcohol test or urinalysis specimen test, will medically disqualify me from the operation of a controlled commercial motor vehicle.

Substances that are tested for are: alcohol, marijuana, cocaine, opiates, amphetamines, phencyclidine (PCP).

The contracted Medical Review Officer will confirm and report the test results to Department management. Negative and positive test results, and identification of the controlled substance for positive tests, will be reported to the Human Resource office, the designated regional supervisor/bureau chief and direct supervisor and become a part of my confidential Driver Qualification File. In addition, I understand that my written authorization is required for the results to be given to any other parties.

Refusal to test will result in disqualification for a commercial driver's licensed safety sensitive position at the Department and/or dismissal.

****

CDL drivers or driver applicants may request alcohol or controlled substances test results. Notification of results will be made if this part is signed and dated.
I hereby request the alcohol and/or controlled substances test results as conducted according to the Federal Motor Carrier Safety Regulation 49 CFR Part 40.

_____ _____

Date Tested Employee or Applicant Name (please print)

_____

Street Address City State Zip

Reason for Test:

__ Pre-Employment
__ Random
__ Reasonable Suspicion
__ Post Accident
__ Return-to-Duty or Follow-up

_____

Employee or Applicant Signature

EAP AND FOLLOW-UP TESTING AGREEMENT

Idaho Department of Parks and Recreation Memorandum

CONFIDENTIAL

DATE:

TO:

FROM:

SUBJECT: EAP AND FOLLOW-UP TESTING AGREEMENT

This memorandum is to confirm our discussion today regarding your recent alcohol and/or controlled substances test and to set out the terms under which your employment can continue at the Idaho Department of Parks and Recreation (Department). The Department is strongly committed to providing a safe workplace and promoting high standards of health and safety for our employees with a workplace free from the effects of alcohol misuse or substance abuse. Being free from the effects of alcohol and substance abuse is especially important in Department safety-sensitive positions, such as a commercial motor vehicle operator.

The Department has reviewed the information regarding your recent positive alcohol or drug test, and while a positive test can be grounds for dismissal, the Department has decided to enter into an agreement with you that allows you to continue in your current position, providing you agree to do the following:

1. Schedule an appointment within five (5) days to see a local Employee Assistance Program (EAP) substance abuse professional counselor for an evaluation to determine whether you have an alcohol or substance abuse problem and for a recommendation regarding what treatment, if any, is appropriate.

2. Submit to an alcohol or controlled substances test and receive a negative test result before being allowed to return to work and perform safety sensitive functions as defined in the Department's Alcohol/Controlled Substances Testing policy.

3. Participate in, cooperate with, and comply completely with any follow-up or rehabilitative activities recommended by the EAP or professional counselor. Failure to attend a scheduled rehabilitative meeting could be considered a refusal on your part to comply completely with EAP's recommendations.

4. Allow information relevant to your rehabilitation to be released to designated Department management to determine your compliance with the first three conditions listed above. Before you can be re-qualified as a commercial motor vehicle driver, the EAP or professional counselor will have to recommend that you can return to the job.

5. Undergo unannounced follow-up testing at the Department's request, as prescribed by the substance abuse professional (SAP), to consist of at least **six (6)** tests for the next **twelve (12)** months, and to test negative each time. The follow-up testing is in addition to the DOT required random testing for which you must also test negative each time.

6. Comply with all Department procedures and policies, including attendance and leave.

Failure to comply with any portion of the above requirements may result in your immediate dismissal. In addition, any subsequent positive alcohol or drug test <u>will</u> result in permanent disqualification as a driver of controlled commercial vehicles and in dismissal from employment. You are expected to continue to perform your job duties in a satisfactory manner.

EAP AND FOLLOW-UP TESTING AGREEMENT
(continued)

This memorandum does not affect your ability to resign from the Department at any time for any reason or the Department's ability to terminate your employment at any time for cause, pursuant to personnel regulations. This memorandum only addresses what you must now agree to do if you want to continue to work for the Idaho Department of Parks and Recreation.

Your qualification as a driver of controlled commercial motor vehicles is also subject to your continued compliance to the Department's alcohol and controlled substances testing procedures and Federal Motor Carrier Safety Regulations, 49 CFR 382.

The Department is willing to help you continue to be an employee, is confident that you can meet these commitments and is willing to allow you to do so through this agreement. To continue your employment with the Department, you must comply completely with the terms of this agreement.

I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS AGREEMENT AND I AGREE TO THE CONDITIONS.

Name_____ Date _____

WITNESS ON BEHALF OF THE IDAHO DEPARTMENT OF PARKS AND RECREATION

Name _____ Date _____

Title:

EAP SUBSTANCE ABUSE PROFESSIONAL EVALUATION

1. It is my professional opinion that _____
(print employee name)

can take a return-to-duty alcohol and/or controlled substances test (please circle test(s) involved) on the following date: _____ and will be able to return safely to work as a commercial motor vehicle operator after the negative test result(s) is (are) received.

2. It is my professional opinion that _____
(print employee name)

should continue with the following treatment. Include recommended number of follow-up tests. The regulations require a minimum six (6) tests in the next twelve (12) months, **unless no tests are recommended based on the evaluation):**

_____
_____
_____
_____

Counselor or treatment program referred to:

_____
_____

Further comments or recommendations:

_____
_____
_____

Signed:

Print Name:

Title: _____

Company Name:

Phone Number: _____

Date:

EAP SUBSTANCE ABUSE PROFESSIONAL REFERRAL LETTER
CONFIDENTIAL

[DATE]

Dear [EAP Counselor]:

[Employee's name] has been formally referred to you by the Idaho Department of Parks and Recreation for evaluation to determine the extent of any substance abuse problem and what counseling or treatment might be needed to safely return this employee to work in a position whose job duties require the operation of a commercial motor vehicle for the Idaho Department of Parks and Recreation. Due to *Federal Regulations 49 CFR Part 382*, and because of the safety sensitive nature of the operator's job, the Department requires an Employee Assistance Program (EAP) substance abuse professional to evaluate this employee. A return-to-duty test date to obtain a negative test result and determine that returning the operator to [his or her] job does not pose a threat to the safety of that operator, or to others on the public roadways, must also be established either by you or by the substance abuse professional of any rehabilitation program to which you refer the employee.

A copy of the Federal Regulations, Part 382, Subpart E - Consequences For Drivers Engaging in Substance Use-Related Conduct, is enclosed for your reference.

Please provide information on whether *[employee's name]* is requalified to drive by answering the questions on the attached Substance Abuse Professional Evaluation form or providing a separate statement that addresses these issues. While the decision to return this employee to work is the Department's, your input can aid in determining whether return-to-duty is appropriate.

Thank you in advance for your prompt attention to this important matter.

Sincerely,

Human Resource Officer

Return the enclosed evaluation in a confidential envelope to:

Human Resource Office
Idaho Department of Parks and Recreation
P.O. Box 83720
Boise, ID 83720-006

Reasonable Cause Compliance Report

Department of Transportation Code of Federal Regulation 49 Part 40

Month_____ Day_____Year_____Time:_____AM PM
Program Administrator:_____
Name of Person Completing Report:_____ Title:_____
Employee Name:_____ SS#: _____
Job Function:_____ Immediate Supervisor:_____
Briefly State Initial Action/ Behavior Observed:_____

_____

_____

_____

The determination that Reasonable Cause exists must be based on the specific, contemporaneous, articulable behavior, speech or body odors of the Employee. The observations may include indications of the chronic and withdrawal effects of controlled substances/alcohol. The required observations must be made by 2 (two) Supervisors or Company Officials, one of whom must have been trained in the signs and symptoms of controlled substance abuse/alcohol misuse. However, for Employers other than 121 Certificate holders, with 50 or fewer "Safety Sensitive" Employees, the requirement is reduced to 1 (one) trained Supervisor. Documentation of the grounds for Reasonable Cause to require a Controlled Substance/Alcohol Test must be made and signed by the Supervisor / Employer within 24 hours of the observed behavior or before the results of the test are released, whichever is later.

- ***Interview Information:*** Location of Interview:_____

Are you under the care of a Doctor/Dentist? ___YES ___NO Why?_____
Are you taking any medications or Drugs? ___YES ___NO If Yes, what?:_____

Last dose taken: Date: _____ Time:_____

Are you Diabetic or Epileptic?___ YES ___NO Are you taking Insulin? ___YES ___NO
What and When have you eaten today? _____
What have you been drinking?_____
How much?_____Time of Last Drink?_____

- ***Observed Condition:***

Breath Odor Liquor/Alcohol: __None __Faint __Moderate __Strong
Body Odor: __None __Alcohol __Marijuana ___Other: _____
Color of Face:___Normal ___Pale ___Red ___Other:_____
Balance: __ Sure __Wobbling __Swaying __Falling __Other: _____
Pupils: __ Normal __Dilated __Constricted __Poor Reaction to Light
Walking: __Fair __Sure __ Swaying __Uncertain __Falling __Stumbling __Staggering __Other: _____
Attitude: __Polite __Carefree __Insulting __Excited __Sleepy __Combative __Hilarious __Cooperative __Antagonistic __Talkative __Other:_____
Speech: __Fair __ Stuttering __Slurred __Incoherent __Confused

Is the clearness and correctness of enunciation abnormal for the individual? ___YES ___NO

➢ ***Other Information:*** The observations were made

___ *While* the Employee was performing a safety-sensitive function
___ Just *before* the Employee performed a safety-sensitive function
___ Just *after* the Employee ceased performing a safety-sensitive function

The above observations were made by:_____
Print Name

Trained in accordance with Regulatory Requirements? __YES __NO Date of Training_____ Trained By: _____

I, the undersigned, determine that the involved Employee, based on specific, contemporaneous, articulable observations concerning the appearance, behavior, speech or body odors of the Employee as indicated above, is in violation of the prohibitions concerning the following:

___ Alcohol Misuse ___ Controlled Substance Use ___ Both Alcohol and Controlled Substance Use

_____ _____ _____AM PM
Signature of Employer/Supervisor Date Time

An Employee shall be required to submit to an Alcohol and/or Controlled Substances test when the Employer/Supervisor has Reasonable Cause to believe that the Employee has violated the prohibitions concerning alcohol and/or controlled substances. Any Employee required to test *must be escorted* to the testing site or on-site testing location.

Required Test Information:

- **A** Was the above Employee tested for Alcohol detection with an approved Evidential Breath Testing (EBT) device **within 2 hours** following the determination of Reasonable Cause for Alcohol misuse? ___ YES ___ NO If no, Why? _____
- **B** Was the above Employee tested for Alcohol detection with an approved Evidential Breath Testing (EBT) device **within 8 hours** following the determination of Reasonable Cause for Alcohol misuse? ___ YES ___ NO If no, Why? _____
- **C** Was the above Employee tested for Controlled Substances as required following the determination of Reasonable Cause for Controlled Substances? ___ YES ___ NO If no, Why? _____

➢ **If A B or C were answered *NO*, please complete the Reason for Not Testing Form**

Reasonable Cause Reasons for Not Testing

Department of Transportation Code of Federal Regulation 49 Part 40

A Explain the Reason(s) why the Employee did not test for Alcohol within 2 (two) hours as required by the Department of Transportation:_____

_____

_____

B Explain the Reason(s) why the Employee did not test for Alcohol within 8 (eight) hours as required by the Department of Transportation: _____

_____

_____

C Explain the Reason(s) why the Employee did not test for Substance Abuse after Reasonable Cause Determination as required by the Department of Transportation:

_____

_____

_____

Additional Comments:_____

_____

FEDERAL LAW *PROHIBITS* THE PERSON WHO DETERMINES THAT *REASONABLE CAUSE* EXISTS TO CONDUCT THE ALCOHOL TEST ON THE DRIVER

Collection Site:_____

Was the Employee escorted to the testing site: __YES __NO ___Refused to go to testing site

Name of Escort_____

Did Driver submit to Controlled Substance test? __YES __Refused

Did Driver submit to Alcohol test? __ YES __Refused

Name of **Collector:**_____ Name of **Breath Alcohol Technician:** _____

Additional Information Regarding test(s):_____

_____

Notwithstanding the absence of a Reasonable Cause Alcohol Test, no Driver shall report for duty or remain on duty requiring the performance of safety sensitive functions while the Driver is under the influence of or impaired by Alcohol as shown by the behavior, speech and performance indicators of Alcohol Misuse, nor shall an Employer or Supervisor permit the Driver to perform or continue to perform safety sensitive functions until:

1. **An Alcohol test is administered and the Driver's Alcohol concentration measures less than 0.02 or**
2. **24 hours have elapsed following the determination that there is a Reasonable Cause to believe that the Driver has violated the prohibitions concerning the misuse of Alcohol.**

Except as specified above, no Employer or Supervisor shall take any action against a Driver **based *solely* on the Driver's behavior** and appearance, with respect to Alcohol use in the absence of an Alcohol test. This does not prohibit an Employer or Supervisor from taking action otherwise consistent with the law.

DISPOSITION or ACTION TAKEN:_____

_____

Employee: I, the undersigned state to the best of my knowledge, that the above information is true and correct.

Signature: _____ Date:_____

I, (we) *the undersigned*, state to the best of my (our) knowledge, that the above information is true and correct.

PREPARER:
Signature:_____
Name:_____
Date:_____

PROGRAM ADMINISTRATOR:
Signature:_____
Date:_____

POST ACCIDENT Report

Department of Transportation Code of Federal Regulation 49 Part 40 and Part 382 Federal Motor Carriers Safety

Company Name_____ Phone: (_____)_____
Date of Accident:_____ City_____ County_____ State_____
Employees___Involved ____Injured _____Killed
Non-Employees _____Involved _____Injured _____Killed

_____ _____
Name of Program Administrator Name of Person Completing this form

_____ ____|____ _____
Name of Employee involved in Accident State Class Social Security #

_____ _____ _____ _____
Vehicle # Was this Employee injured? Was the injury major or minor?

Injured transported by_____ Taken to_____

Describe injuries ***(if any)***_____

_____

- A Was the above Employee tested for Alcohol detection with an approved Evidential Breath Testing (EBT) device within 2 (two) hours after the accident occurred? ___YES ____NO
- B Was the above Employee tested for Alcohol detection with an approved Evidential Breath Testing (EBT) device **within 8 (eight) hours** after the accident occurred? ____YES ____NO
- C Ws the above Employee tested for controlled substances within **32 (thirty-two) hours** after the accident occurred? ____YES ____NO
- If the answer is NO to A B or C, please explain (in detail on Page 3) why the above Employee **was not** tested within the appropriate time.

LOCATION:
Accident
Occurred: M T W Th F S Sun Month:____Day:____ Year:___Time ____am pm
Posted Speed **Limit**_____ **at:**_____
Nearest cross street or highway:_____

Direction of travel: N S E W NE NW SE SW
Was vehicle towed away**?** _____**Yes** _____**No**

WEATHER

___Clear ___Cloudy ___Raining ___Snowing ___ Wind ___Fog:visibility _____feet
___Other:_____

LIGHTING

__Daylight __Dusk-Dawn __Dark - Street Lights __Dark - No Street Lights __Dark - Street Lights non functioning __**Other:** _____

ROAD SURFACE

__Dry __Wet __Flooded __Snowy __Icy __Slippery, Muddy, Oily, etc.
__Other:_____

ROADWAY CONDITIONS

__Holes, Deep Rut __**Loose Material on Road** __**Construction** on Roadway __Construction Repair Zone __Reduced Roadway Width __ No Unusual Conditions
__Other_____

OTHER ASSOCIATED FACTORS

__ Vision Obscurement __ Inattention __Stop & Go Traffic __Unfamiliar with Road __Runaway Vehicle __None Apparent __Other_____

TYPE of VEHICLE

__School Bus __Other Bus __Truck __ Truck Tractor __Truck Tractor with Trailer
__Other_____

OTHER MOTOR VEHICLE INVOLVED

__NON COLLISION __**Pedestrian** __**Other Motor Vehicle** __**Motor Vehicle on other Roadway**
__**Parked** Motor Vehicle __Train __Bicycle __Motorcycle __Animal_____
Fixed Object: _____ __Other:_____

MOVEMENT PRECEDING COLLISION

__Stopped ___ Proceeding Straight __Ran Off Road __Making Right Turn __Making Left Turn
__Backing __Slowing/Stopping __Passing Other Vehicle __Changing Lanes __Entering Traffic
__Other Unsafe Turning __Parking Maneuver __ Crossing into Opposing Lane __ Parked __Merging
__Traveling Wrong Way __Other:_____

TYPE of COLLISION
__ Head-on __Sideswipe __Rear End __ Broadside __Hit Object __Hit Vehicle/Pedestrian
__Other:_____

SPEED **Approximate Speed of Vehicle :**_____ **MPH**

WAS EMPLOYE CITED? _____ If Yes, complete next page

Signature of Person who
Completed this Information:_____
Date: _____ **Time:**_____ **AM PM**

Reasonable Cause Reasons for Not Testing

Department of Transportation Code of Federal Regulation 49 Part 40

A Explain the Reason(s) why the Employee did not test for Alcohol within 2 (two) hours as required by the Department of Transportation:_____

_____

_____

B Explain the Reason(s) why the Employee did not test for Alcohol within 8 (eight) hours as required by the Department of Transportation: _____

_____

_____

C Explain the Reason(s) why the Employee did not test for Substance Abuse after Reasonable Cause Determination as required by the Department of Transportation:

_____

_____

_____

Additional Comments:_____

_____

FEDERAL LAW *PROHIBITS* THE PERSON WHO DETERMINES THAT *REASONABLE CAUSE* EXISTS TO CONDUCT THE ALCOHOL TEST ON THE DRIVER

Collection Site:_____

Was the Employee escorted to the testing site: __YES __NO ___Refused to go to testing site

Name of Escort_____

Did Driver submit to Controlled Substance test? __YES __Refused

Did Driver submit to Alcohol test? __ YES __Refused

Name of **Collector:**_____ Name of **Breath Alcohol Technician:** _____

Additional Information Regarding test(s):_____

_____

Notwithstanding the absence of a Reasonable Cause Alcohol Test, no Driver shall report for duty or remain on duty requiring the performance of safety sensitive functions while the Driver is under the influence of or impaired by Alcohol as shown by the behavior, speech and performance indicators of Alcohol Misuse, nor shall an Employer or Supervisor permit the Driver to perform or continue to perform safety sensitive functions until:

1. **An Alcohol test is administered and the Driver's Alcohol concentration measures less than 0.02 or**
2. **24 hours have elapsed following the determination that there is a Reasonable Cause to believe that the Driver has violated the prohibitions concerning the misuse of Alcohol.**

Except as specified above, no Employer or Supervisor shall take any action against a Driver **based *solely* on the Driver's behavior** and appearance, with respect to Alcohol use in the absence of an Alcohol test. This does not prohibit an Employer or Supervisor from taking action otherwise consistent with the law.

DISPOSITION or ACTION TAKEN:_____

_____

Employee: I, the undersigned state to the best of my knowledge, that the above information is true and correct.

Signature: _____Date:_____

I, (we) *the undersigned*, state to the best of my (our) knowledge, that the above information is true and correct.

PREPARER:
Signature:_____
Name:_____
Date:_____

PROGRAM ADMINISTRATOR:
Signature:_____
Date:_____